

Urology Questionnaire

		Year _____ Month _____ Day _____	
Name	(Male/Female)	Birth Date	Year _____ Month _____ Day _____
		Nationality()	Age ()
Adress	〒		
Number			

◆What brought you here today?

- ☐difficulty urinating ☐frequent urination ☐urinary incontinence ☐slow stream
☐feeling of incomplete emptying ☐fever ☐pain when urinating ☐low back pain (right・left)
☐bloody urine ☐sexually transmitted disease (☐need a rapid test) ☐genital abnormalities
☐abnormal medical examination(occult blood/proteinuria/PSA/others) ☐erectile dysfunction
☐late onset hypogonadism ☐AGA trea
tment ☐others()

◆How long have you had these problems? (Since Year _____ Month _____ Day _____)

◆What illnesses have you had in the past?

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◆Are you currently taking medication?

☐Yes () ☐No

◆Do you have any food or medication allergies?

☐Yes () ☐No

◆Have you ever had any operations?

☐Yes () ☐No

◆Do you drink alcohol? ☐Yes () ☐No

◆Do you smoke? ☐Yes () ☐No

Only female

★Are you pregnant or is there a possibility of pregnancy? ☐Yes ☐No

★Are you currently breastfeeding? ☐Yes ☐No